ESSENCE
WELLNESS CLINIC

PEDIATRIC INTAKE

Patient Information:

Name: _____ Date: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: (H) _____(Cell) _____

Date of Birth: _____(YYYY/MM/DD) Age: ____ Sex: M / F / □ _____

Occupation: _____ Email: _____

By providing my email, I agree to receiving clinic email reminders, health updates, promotions, etc.

In case of emergency, who should we contact: _____

How did you find out about our services? _____

Patient Health History:

Please list your child's health concerns (from major to minor):

1. _____
2. _____
3. _____

Please list all accidents, surgeries or hospitalizations and the year they occurred:

_____ _____

_____ _____

Please list any medications and supplements your child is currently taking:

_____

_____

Is your child currently seeing any other alternative health care professionals?

_____

Please list all allergies:

_____

When was your child's last physical exam? _____

When was your child's last blood test? _____

Family Doctor's name: _____

Clinic name: _____ Phone number: _____

Family Medical History:

Please list all family members who have any major health conditions:

_____

_____

Which of the following has your child had? (N=never, M=mild, A=average, S=severe)

___ Rubella (German Measles)	___ Chicken Pox	___ Impetigo	___ Mumps
___ Ear Infections	___ Scarlet Fever	___ Strept Throat	___ Measles
___ Mononucleosis	___ Roseola	___ Whooping Cough	

Please indicate what immunizations your child has had:

___ DPT (diptheria, pertussis, tetanus)	___ Hepatitis A	___ Hepatitis B
___ Tetanus booster, when? _____	___ Flu vaccine	___ Polio
___ MMR (measles, mumps, rubella)	___ Haemophilus influenza B	

How many times has your child been treated with antibiotics? _____

Was your Child breast fed, How long? _____ Formula/Milk/Soy/Other:_____

Consent for Treatment with Essence Wellness Clinic

I am hereby requesting □ **Acupuncture** □ **Massage** □ **Naturopathic** treatments from Essence Wellness Clinic. New complications and concerns, if they do arise, will be discussed with my practitioner/therapist, and appropriate action will be taken. I understand that although these are natural and alternative treatments I am seeking, there may be risks of bruising, pain in treated area, and worsening of symptoms during the healing process. I also understand that there are no guarantees for cure for any of my ailments or improvements of my symptoms. I hereby release Essence Wellness and all practitioners/therapists treating me from all liabilities.

I am also aware of the clinic's late cancellation policy of a charge of **50% of the visit cost** if I fail to give **less than 24 hours notice for cancellations**. **I will be responsible to pay that charge before I can re-book.**

Signature of parent/guardian _____

Name of parent/guardian_____

Date_____